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may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.

(u) *Intermingling*. A building housing a facility recognized as a State home for providing nursing home care may only provide nursing home care in the areas of the building recognized as a State home for providing nursing home care.

(v) *VA Management of State Veterans Homes*. Except as specifically provided by statute or regulations, VA employees have no authority regarding the management or control of State homes providing nursing home care.

(Authority: 38 U.S.C. 101, 501, 1710, 1741–1743, 8135)

PART 58—FORMS

Sec.

58.10 VA Form 10-3567—State Home Inspection: Staffing Profile.

58.11 VA Form 10-5588—State Home Report and Statement of Federal Aid Claimed.

58.12 VA Form 10-10EZ—Application for Health Benefits.

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58.14 VA Form 10-0143A—Statement of Assurance of Compliance with Section 504 of The Rehabilitation Act of 1973.

58.15 VA Form 10-0143—Department of Veterans Affairs Certification Regarding Drug-Free Workplace Requirements for Grantees Other Than Individuals.

58.16 VA Form 10-0144—Certification Regarding Lobbying.

58.17 VA Form 10-0144A—Statement of Assurance of Compliance with Equal Opportunity Laws.

AUTHORITY: 38 U.S.C. 101, 501, 1710, 1741–1743.

SOURCE: 65 FR 981, Jan. 6, 2000, unless otherwise noted.

§ 58.10 VA Form 10-3567—State Home Inspection Staffing Profile.

OMB Approved No. 2500-0160
Estimated Burden Avg. 20 min.

Department of Veterans Affairs		STATE HOME INSPECTION		
NAME OF HOME				DATE OF INSPECTION
PART I	TOTAL FACILITY	HOSPITAL	NHC	DOM
OPERATING BEDS				
AUTHORIZED APPROVALS				
PATIENT CENSUS				
POSITIONS AUTHORIZED				
STAFF AVAILABLE				
PART II - STAFF	TOTAL FACILITY	HOSPITAL	NHC	DOM
PHYSICIANS:				
PHYSICIANS ASSISTANTS				
DENTISTS				
SOCIAL WORK: MSW				
BSW				
SOCIAL WORK ASSISTANT				
PHARMACY: REG. PHARMACIST				
DIETETICS: REG. DIETITIAN				
FOOD SUPERVISOR				
DIETARY ASSISTANTS				
NURSING:				
NURSING ADM./SUP.				
DIRECT CARE: CERT. N.P./C.N.S.				
R.N.				
L.P.N./L.V.N.				
N.A.				
REHABILITATION THERAPY				
REG. P.T./P.T. AIDES				
REG. O.T./O.T. AIDES				
MENTAL HEALTH: PSYCHOLOGIST				
PSYCHIATRIST				
PSYCHIATRIC SOCIAL WORKER				
COUNSELOR				
SPEECH AND AUDIOLOGY				
OPHTHALMOLOGY/OPTOMETRY				
PODIATRY				
RADIOLOGY/LABORATORY				
RECREATION/ACTIVITIES				
DIRECTOR				
ASSISTANTS				
VOLUNTEERS				
CHAPLAIN				
ADMINISTRATION				
ENGINEERING				
MAINTENANCE/HOUSEKEEPING				
MEDICAL RECORDS				
OTHER (Specify)				

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10-3567

SEE REVERSE

NAME OF HOME	DATE OF INSPECTION
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NURSING SERVICE STAFFING PATTERN
(Four Week Average)

PART III		HOSPITAL (Average hours Hosp. _____)																							
SHIFT	SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY						
	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA				
DAY																									
EVENING																									
NIGHT																									

PART IV		NURSING HOME (Average hours NHC _____)																							
SHIFT	SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY						
	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA				
DAY																									
EVENING																									
NIGHT																									

PART V		DOMICILIARY (Average hours Dom. _____)																							
SHIFT	SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY						
	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA				
DAY																									
EVENING																									
NIGHT																									

NAME OF HOME	DATE OF INSPECTION
<p>The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.</p>	

§ 58.11

38 CFR Ch. I (7-1-00 Edition)

§ 58.11 VA Form 10-5588—State Home Report and Statement of Federal Aid Claimed.

OMB Approval No. 2900-0160
Estimated Burden: Avg. 30 min.

Department of Veterans Affairs							
STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED							
TO	VA FACILITY		FROM	NAME AND ADDRESS OF STATE HOME			
PAY TO				FOR MONTH ENDING			
LINE NO.	ITEM	DOMICILIARY (A)	NURSING HOME CARE (B)	HOSPITAL (C)	ADULT DAY HEALTH CARE (D)		
1	TOTAL VETERAN RESIDENTS REMAINING AT END OF PRIOR MONTH						
2	GAINS	ADMISSIONS (Change of status)					
3		ADMISSIONS (Other)					
4		RETURNS FROM LEAVE OF ABSENCE OF MORE THAN 96 HOURS					
5	LOSSES	DISCHARGES (Change of status)					
6		DISCHARGES (Other)					
7		DEATHS					
8		LEAVES OF ABSENCE OF MORE THAN 96 HOURS					
9	TOTAL VETERAN RESIDENTS REMAINING AT END OF THE MONTH						
10	TOTAL VETERAN DAYS OF CARE FURNISHED						
11	FEMALE VETERAN RESIDENTS REMAINING AT END OF THE MONTH						
12	NON-VETERAN RESIDENTS REMAINING AT END OF THE MONTH						
MONTHLY STATEMENT OF ACCOUNT							
LINE NO.	FEDERAL AID CLAIMED UNDER SEC. 1741, TITLE 38, U.S.C., AS AMENDED	DAYS OF CARE (J)	AVERAGE DAILY CENSUS (K)	TOTAL PER DIEM COST (L)	PER DIEM CLAIMED (M)	TOTAL AMOUNT CLAIMED (N)	
13	DOMICILIARY CARE			\$	\$	\$	
14	NURSING HOME CARE			\$	\$	\$	
15	HOSPITAL CARE			\$	\$	\$	
16	ADULT DAY HEALTH CARE			\$	\$	\$	
17	TOTAL AMOUNT CLAIMED					\$	
FOR DEPARTMENT OF VETERANS AFFAIR USE ONLY							
RECEIVING REPORT - Services authorized under provisions of Sec. 1741, 1742 and 1743, Title 38, U.S.C., have been rendered in the quantity claimed and payment is recommended except as follows:			SIGNATURE AND TITLE OF STATE HOME COORDINATOR		DATE		
			ACCOUNTING CERTIFICATION - AUDIT BLOCK				
			AMOUNT DUE	DATE	VOUCHER AUDITOR		

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Department of Veterans Affairs			
STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED			
I certify that this report is correct, that all residents included in the report were physically present during the period for which Federal aid is claimed, except for authorized absences of 96 hours or less, and that facility management has complied with all provisions of Title VI, Public Law 88-352, entitled Civil Rights Act of			
TOTAL STATE OPERATING BEDS AT END OF THE MONTH			
DOMICILIARY CARE	NURSING HOME CARE	HOSPITAL CARE	ADULT DAY HEALTH CARE
BED CAPACITY APPROVED BY VA			
DOMICILIARY CARE	NURSING HOME CARE	HOSPITAL CARE	ADULT DAY HEALTH CARE
SIGNATURE OF STATE HOME ADMINISTRATOR			DATE
SIGNATURE OF STATE EMPLOYEE WHEN APPLICABLE			DATE
REMARKS			
<p>The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.</p>			

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SEP 1998 (RS) **10-5588**

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§ 58.12

38 CFR Ch. I (7-1-00 Edition)

§ 58.12 VA Form 10-10EZ—Application for Health Benefits

OMB Approved No. 2900-0097
Estimated Burden Avg. 20 min

Department of Veterans Affairs		APPLICATION FOR HEALTH BENEFITS	
SECTION I - GENERAL INFORMATION			
1A. TYPE OF BENEFIT(S) APPLIED FOR (You may check more than one)			
<input type="checkbox"/> HEALTH SERVICES <input type="checkbox"/> NURSING HOME <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> DENTAL <input type="checkbox"/> ENROLLMENT			
1B. IF APPLYING FOR HEALTH SERVICES, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER			
2. VETERAN'S NAME (Last, First, MI)		3. OTHER NAMES USED	
5. SOCIAL SECURITY NUMBER		4. GENDER (Check one) <input type="checkbox"/> M <input type="checkbox"/> F	
6. CLAIM NUMBER		7. DATE OF BIRTH (mm dd yyyy)	
8. RELIGION			
9A. CURRENT MAILING ADDRESS (Street)		9B. CITY	
9C. STATE		9D. ZIP	
9E. COUNTY		10. HOME TELEPHONE NUMBER	
		11. WORK TELEPHONE NUMBER	
12. CURRENT MARITAL STATUS (Check one)			
<input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> UNKNOWN			
13A. LAST BRANCH OF SERVICE	13B. LAST ENTRY DATE	13C. LAST DISCHARGE DATE	13D. DISCHARGE TYPE
13E. MILITARY SERVICE NUMBER			
14. CIRCLE YES OR NO			
A. ARE YOU A FORMER PRISONER OF WAR		YES	NO
B. DO YOU HAVE A VA SERVICE CONNECTED RATING		YES	NO
81. IF YES, WHAT IS YOUR RATED PERCENTAGE		%	
C. ARE YOU RECEIVING A VA PENSION		YES	NO
D. ARE YOU RETIRED FROM THE MILITARY		YES	NO
D1. WAS YOUR RETIREMENT THE RESULT OF A DISABILITY		YES	NO
D2. WERE YOU REGULARLY RETIRED (120 - yrs)		YES	NO
E. WERE YOU EXPOSED TO TOXINS IN THE GULF WAR		YES	NO
F. WERE YOU EXPOSED TO AGENT ORANGE		YES	NO
G. WERE YOU EXPOSED TO RADIATION		YES	NO
H. DO YOU HAVE A MILITARY DENTAL INJURY		YES	NO
I. DO YOU HAVE A SPINAL CORD INJURY		YES	NO
J. ARE YOU ELIGIBLE FOR MEDICAID		YES	NO
K. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A		YES	NO
K1. EFFECTIVE DATE			
L. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B		YES	NO
L1. EFFECTIVE DATE			
M. MEDICARE CLAIM NUMBER			
N. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD			
15A. VETERAN'S EMPLOYMENT STATUS (check one) If employed or retired, complete item 15B		15B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER	
<input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> EMPLOYED <input type="checkbox"/> RETIRED Date of retirement			
16A. SPOUSE'S EMPLOYMENT STATUS (check one) If employed or retired, complete item 16B		16B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER	
<input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> EMPLOYED <input type="checkbox"/> RETIRED Date of retirement			
17A. VETERAN'S HEALTH INSURANCE COMPANY		18A. SPOUSE'S HEALTH INSURANCE COMPANY	
17B. NAME OF POLICY HOLDER		18B. NAME OF POLICY HOLDER	
17C. POLICY NUMBER	17D. GROUP CODE	18C. POLICY NUMBER	18D. GROUP CODE
19A. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN		19B. NEXT OF KIN'S HOME TELEPHONE NUMBER	
		()	
		19C. NEXT OF KIN'S WORK TELEPHONE NUMBER	
		()	
20A. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT		20B. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER	
		()	
		20C. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER	
		()	
21. I DESIGNATE THE FOLLOWING INDIVIDUAL TO RECEIVE POSSESSION OF ALL MY PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER MY DEPARTURE OR AT THE TIME OF MY DEATH. (Check one) (This does not constitute a will or transfer of title.)			
<input type="checkbox"/> EMERGENCY CONTACT <input type="checkbox"/> NEXT OF KIN			
22A. IS NEED FOR CARE DUE TO ON THE JOB INJURY (Check one)		22B. IS NEED FOR CARE DUE TO ACCIDENT (Check one)	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

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APPLICATION FOR HEALTH BENEFITS, Continued		VETERAN'S NAME		SOCIAL SECURITY NUMBER
SECTION II - FINANCIAL ASSESSMENT				
IIA - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)				
1. SPOUSE'S NAME (Last, First, MI)		2. CHILD'S NAME (Last, First, MI)		
3. SPOUSE'S SOCIAL SECURITY NUMBER	4. SPOUSE'S DATE OF BIRTH (mm/dd/yyyy)	5. CHILD'S DATE OF BIRTH (mm/dd/yyyy)		
6. SPOUSE'S ADDRESS (Street, City, State, ZIP)		7. CHILD'S SOCIAL SECURITY NUMBER		
8. SPOUSE'S TELEPHONE NUMBER		9. CHILD'S RELATIONSHIP TO YOU (Circle one) Son Daughter Stepson Stepdaughter		
10. DATE OF MARRIAGE (mm/dd/yyyy)		11. DATE CHILD BECAME YOUR DEPENDENT		
12. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT SPOUSE \$ CHILD \$		13. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING (tuition, books, materials, etc.) \$		
14. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? <input type="checkbox"/> YES <input type="checkbox"/> NO		15. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IIB - FINANCIAL DISCLOSURE				
<p>You are not required to provide the financial information in this Section. However, current law may require VA to consider your household financial situation to determine your eligibility for enrollment and/or cost-free care of your nonservice-connected (NSC) conditions. If you are 0% SC noncompensable or NSC (and are not an Ex-POW, WWI veteran or VA pensioner) and your annual household income (or combined income and net worth) exceeds the established threshold, you must agree to pay VA co-payments for care of your NSC conditions to be eligible for enrollment. See Section III - Consent and Signature.</p> <p><input type="checkbox"/> YES, I WILL PROVIDE SPECIFIC INCOME AND/OR ASSET INFORMATION TO HAVE ELIGIBILITY FOR CARE DETERMINED. Complete all sections below that apply to you with last calendar year's information. Sign and date the application.</p> <p><input type="checkbox"/> NO, I DO NOT WISH TO PROVIDE MY DETAILED FINANCIAL INFORMATION. I understand I will be assigned the appropriate enrollment priority based on nondisclosure of my financial information. By checking NO and signing below, I am agreeing to pay the applicable VA co-payment. Sign and date the application.</p>				
IIC - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN				
	VETERAN	SPOUSE	CHILDREN	
1. WHAT WAS YOUR GROSS ANNUAL INCOME FROM EMPLOYMENT (wages, bonuses, tips, etc.), AS WELL AS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$	\$	\$	
2. LIST OTHER INCOME SOURCES (Social Security, compensation, pension, interest, dividends). Exclude welfare	\$	\$	\$	
3. WAS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS (if yes, refer to page 2, Section IIC of the instructions)? <input type="checkbox"/> YES <input type="checkbox"/> NO				
IID - DEDUCTIBLE EXPENSES				
1. NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE (payments for doctors, dentists, drugs, Medicare, health insurance, hospital and nursing home)		\$		
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD (Also enter spouse or child's information in Section IIA)		\$		
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES (tuition, books, fees, materials, etc.) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.		\$		
IIE - NET WORTH				
	VETERAN	SPOUSE		
1. CASH, AMOUNT IN BANK ACCOUNTS (Checking and savings accounts, certificates of deposit, individual retirement accounts, etc.)	\$	\$		
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. Do not count your primary home. Include value of farm, ranch, or business assets.	\$	\$		
3. STOCKS AND BONDS AND VALUE OF OTHER PROPERTY OR ASSETS (art, rare coins, etc.) MINUS THE AMOUNT YOU OWE ON THESE ITEMS. Exclude household effects and family vehicles.	\$	\$		
SECTION III - CONSENT AND SIGNATURE				
<p>CO-PAYMENT NOTICE: If you are a 0% service-connected noncompensable or a nonservice-connected veteran (and are not an Ex-POW, WWI veteran or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, you may be eligible for enrollment only if you agree to pay VA co-payments for treatment of your NSC conditions. By signing this application you are agreeing to pay the applicable VA co-payment if required by law.</p> <p>I CERTIFY THE FOREGOING STATEMENT(S) ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY.</p>				
SIGN HERE		DATE (mm/dd/yyyy)		
(Signature of applicant or applicant's representative)				
THE LAW PROVIDES SEVERE PENALTIES FOR WILLFUL SUBMISSION OF FALSE INFORMATION.				

§ 58.13

38 CFR Ch. I (7-1-00 Edition)

§ 58.13 VA Form 10-10SH—State Home Program Application for Veteran Care Medical Certification.

OMB Approval No. 2900-0160
Estimated Burden: Avg. 30 min.

Department of Veterans Affairs		STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION			
PART I - ADMINISTRATIVE					
STATE HOME FACILITY				DATE ADMITTED	GENDER M F
RESIDENT'S NAME (Last, First, Middle)				SOCIAL SECURITY NUMBER	
RESIDENT'S STREET ADDRESS				AGE	DATE OF BIRTH
CITY, STATE AND ZIP CODE				ADVANCED MEDICAL DIRECTIVE NO YES	
PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary)					
HISTORY					
HEIGHT	WEIGHT	TEMP	PULSE	BP	HEAD/EYES/EAR/NOSE AND THROAT
NECK			CARDIOPULMONARY		
ABDOMEN			GENITOURINARY		
RECTAL			EXTREMITIES		
NEUROLOGICAL			ALLERGY/DRUG SENSITIVITY		
X-RAY/ LAB	CHEST X-RAY	DATE:	RESULTS	CBC	DATE: RESULTS
	SEROLOGY				
	URINALYSIS	DATE	ALBUMEN	SUGAR	ACETONE
CHECK ALL BOXES THAT APPLY OR CIRCLE NA					
IS DEMENTIA THE PRIMARY DIAGNOSIS		IS THERE A DIAGNOSIS OF MENTAL ILLNESS		HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS	
YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:					
SCHIZOPHRENIA		PARANOIA		OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY	
MOOD SWINGS		SOMATOFORM DISORDER		PANIC OR SEVERE ANXIETY DISORDER PERSONALITY DISORDER	
OXYGEN		TUBE FEEDING		DECUBITUS ULCERS	
MASK	PRN	OSTOMY	WOUND CULTURED	FOLEY CATHETER	
NASAL CANULAR	CONTINUOUS	TRACHOSTOMY		TEMPORARY PERMANENT	
REFERRING PHYSICIAN				PRIMARY DIAGNOSIS	
SECONDARY DIAGNOSIS				TERTIARY DIAGNOSIS	
TYPE OF CARE RECOMMENDED: SKILLED NURSING HOME CARE DOMICILIARY CARE ADULT DAY HEALTH CARE HOSPITAL					
MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY					
PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED				SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED	

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STATE HOME PROGRAM APPLICATION FOR VETERAN CARE - MEDICAL CERTIFICATION, CONTINUED			
RESIDENT'S NAME (Last, First, Middle)		SOCIAL SECURITY NUMBER	
EVALUATION (Circle appropriate number in each category)			
COMMUNICATION	1. Transmits messages/receives information 2. Limited ability 3. Nearly or totally unable	SPEECH	1. Speaks clearly with others of same language 2. Limited ability 3. Unable to speak clearly or not at all
HEARING	1. Good 2. Hearing slightly impaired. 3. Limited hearing (e.g. - must speak loudly) 4. Virtually/completely deaf	SIGHT	1. Good 2. Vision adequate - Unable to read/see details 3. Vision limited - Gross object differentiation 4. Blind
TRANSFER	1. No assistance 2. Equipment only 3. Supervision only 4. Requires human transfer w/o equipment 5. Bedfast	AMBULATION	1. Independence w/o assistive device 2. Walks with supervision 3. Walks with continuous human support 4. Bed to chair (total help) 5. Bedfast
ENDURANCE	1. Tolerates distances (250 feet sustained activity) 2. Needs intermittent rest 3. Rarely tolerates short activities 4. No tolerance	MENTAL AND BEHAVIOR STATUS	1. Alert 2. Confused 3. Disoriented 4. Comatose 5. Agreeable 6. Disruptive 7. Apathetic 8. Well motivated
TOILETING	1. No assistance 2. Assistance to and from and transfer 3. Total assistance including personal hygiene, help with clothes A. Bathroom B. Bedside commode C. Bedpan	BATHING	1. No assistance 2. Supervision only 3. Assistance 4. Is bathed A. Tub B. Shower C. Sponge bath
DRESSING	1. Dresses self 2. Minor assistance 3. Needs help to complete dressing 4. Has to be dressed	FEEDING	1. No assistance 2. Minor assistance, needs tray set up only 3. Help feeding/encouraging 4. Is fed
BLADDER CONTROL	1. Continent 2. Rarely incontinent 3. Occasional - once/week or less 4. Frequent - up to once a day 5. Total incontinence 6. Catheter, indwelling	BOWEL CONTROL	1. Continent 2. Rarely incontinent 3. Occasional - once/week or less 4. Frequent - up to once a day 5. Total incontinence 6. Ostomy
SKIN CONDITION	1. Intact 2. Dry/Fragile 3. Irritations (Rash) 4. Open wound 5. Decubitus Number _____ Stage _____	WHEEL CHAIR USE	1. Independence 2. Assistance in difficult maneuvering 3. Wheels a few feet 4. Unable to use <input type="checkbox"/> NA
SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN			DATE
PHYSICAL THERAPY (To be completed by Physical Therapist or Referring Physician) <input type="checkbox"/> NEW REFERRAL <input type="checkbox"/> CONTINUATION OF THERAPY			
SENSATION IMPAIRED <input type="checkbox"/> YES <input type="checkbox"/> NO		RESTRICT ACTIVITY <input type="checkbox"/> YES <input type="checkbox"/> NO	
PRECAUTIONS <input type="checkbox"/> CARDIAC <input type="checkbox"/> (OTHER Specify)		FREQUENCY OF TREATMENT	
TREATMENT GOALS: <input type="checkbox"/> STRETCHING <input type="checkbox"/> PASSIVE ROM		ACTIVE <input type="checkbox"/> ACTIVE ASSISTIVE <input type="checkbox"/> PROGRESSIVE RESISTIVE	
COORDINATING ACTIVITIES <input type="checkbox"/> NON-WEIGHT BEARING <input type="checkbox"/> PARTIAL WEIGHT BEARING		FULL WEIGHT BEARING <input type="checkbox"/> PROGRESS BED TO WHEELCHAIR <input type="checkbox"/> RECOVERY TO FULL FUNCTION	
ADDITIONAL THERAPIES <input type="checkbox"/> O.T. <input type="checkbox"/> SPEECH <input type="checkbox"/> DIETARY		SIGNATURE OF AND TITLE OF THERAPIST	
DATE		DATE	
SOCIAL WORK ASSESSMENT (To be completed by Social Worker)			
PRIOR LIVING ARRANGEMENTS		LONG RANGE PLAN	
ADJUSTMENT TO ILLNESS OR DISABILITY		SIGNATURE OF SOCIAL WORKER	
DATE		DATE	
VA AUTHORIZATION FOR PAYMENT			
DATE RECEIVED BY VA		ELIGIBILITY FOR PER DIEM PAYMENT <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	
REASON FOR DISAPPROVAL		LEVEL OF CARE RECOMMENDED <input type="checkbox"/> NHC <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ADHC	
SIGNATURE OF VA OFFICIAL		REASON FOR DISAPPROVAL <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	
DATE		SIGNATURE OF VA PHYSICIAN	
DATE		DATE	

OMB Approval No. 2900-0160
Estimated Burden: Avg. 30 min.

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE


The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information The information requested on this form is solicited under the authority of Title 38, U.S.C., Sections 1741, 1742 and 1743. It is being collected to enable us to determine your eligibility for medical benefits in the State Home Program and will be used for that purpose. The income and eligibility you supply may be verified through a computer matching program at any time and information may be disclosed outside the VA as permitted by law; possible disclosures include those described in the "routine uses" identified in the VA system of records 24VA136, Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. Disclosure is voluntary; however, the information is required in order for us to determine your eligibility for the medical benefit for which you have applied. Failure to furnish the information will have no adverse affect on any other benefits to which you may be entitled. Disclosure of Social Security number(s) of those for whom benefits are claimed is requested under the authority of Title 38, U.S.C., and is voluntary. Social Security numbers will be used in the administration of veterans benefits, in the identification of veterans or persons claiming or receiving VA benefits and their records and may be used for other purposes where authorized by Title 38, U.S.C., and the Privacy Act of 1974 (5 U.S.C. 552a) or where required by other statute.

VA FORM
JUL 1998


10-10SH

§ 58.14 VA Form 10-0143A—Statement of Assurance of Compliance with Section 504 of The Rehabilitation Act of 1973.OMB Number: 2900-0160
Estimated Burden: 5 minutes


 Department of Veterans Affairs	
STATEMENT OF ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973	
<p>The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.</p>	
<div style="text-align: right;">(hereinafter called the "Signatory")</div> <div style="text-align: center;">(Name and location of State Veterans Home)</div>	
HEREBY AGREES THAT	
<p>It will comply with section 504 of the Rehabilitation Act of 1973 (Pub. L. No. 93-112) and all regulations adopted pursuant to such section, for instance, VA Regulations 7800 Series (38 CFR Section 18), to the end that no person in the United States shall, on the ground of handicap, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity of the Signatory receiving Federal financial assistance or other benefits under statutes administered by the VA; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate the agreement.</p>	
<p>If any real property or structure thereon is provided or improved with the aid of the Federal financial assistance extended to the Signatory by the VA, this assurance shall obligate the Signatory, or in the case of transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. In all cases this assurance shall obligate the Signatory for the period during which the Federal financial assistance is extended to any of its programs by the VA.</p>	
<p>THIS ASSURANCE is given in consideration of and for the purpose of obtaining Federal financial assistance, including facilities furnished or payments made under Section 1741 of Title 38 USC. Federal financial assistance is understood to include benefits paid directly to the Signatory, and/or benefits paid to a beneficiary contingent upon such beneficiary being enrolled in a program offered by the Signatory.</p>	
<p>The Signatory recognizes and agrees that such Federal financial assistance or other benefits will be extended in reliance on the representations and agreements made in this assurance, and that the VA will withhold financial assistance, facilities, or other benefits to ensure fulfillment of this assurance of compliance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Signatory, its successors, transferees, and assignees. The person or persons whose signatures appear below are authorized to sign this assurance.</p>	
SIGNATURE OF AUTHORIZED OFFICIAL	
TITLE	DATE
MAILING ADDRESS	

§ 58.15 VA Form 10-0143—Department of Veterans Affairs Certification Regarding Drug-Free Workplace Requirements for Grantees Other Than Individuals.

OMB Number: 2900-0160
Estimated Burden: 5 minutes


 Department of Veterans Affairs
<p align="center">DEPARTMENT OF VETERANS AFFAIRS CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS FOR GRANTEEES OTHER THAN INDIVIDUALS</p>
<p>The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.</p>
<p>This certification is required by the regulations implementing the Drug-Free Workplace Act of 1988, 38 CFR 44, Subpart F. The regulations, published in the January 31, 1989, Federal Register (pages 4950-4952) require certification by grantees, prior to award, that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the agency determines to award the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government-wide suspension or debarment (see CFR Part 44, Section 44.100 through 44.420).</p> <p>The grantee certifies that it will provide a drug-free workplace by:</p> <p>(1) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;</p> <p>(2) Establishing a drug-free awareness program to inform employees about</p> <ul style="list-style-type: none"> (a) The dangers of drug abuse in the workplace; (b) The grantee's policy of maintaining a drug-free workplace; (c) Any available drug counseling, rehabilitation, and employee assistance programs; and (d) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace; <p>(3) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (1);</p> <p>(4) Notifying the employee in the statement required by paragraph (1) that, as a condition of employment under the grant, the employee will</p> <ul style="list-style-type: none"> (a) Abide by the terms of the statement; and (b) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction; <p>(5) Notifying the agency within ten days after receiving notice under subparagraph (4) (b) from an employee or otherwise receiving actual notice of such convictions;</p> <p>(6) Taking one of the following actions, within 30 days of receiving notice under subparagraph (4) (b), with respect to any employee who is so convicted;</p> <ul style="list-style-type: none"> (a) Taking appropriate personnel action against such employee, up to and including termination; or (b) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; <p>(7) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (1), (2), (3), (4), (5) and (6).</p>

OMB Number: 2900-0188
Estimated Burden: 15 minutes

 Department of Veterans Affairs	
DEPARTMENT OF VETERANS AFFAIRS CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS FOR GRANTEEES OTHER THAN INDIVIDUALS	
Places of Performance: The grantee shall insert in the space provided below the site(s) for performance of work done in connection with the specific grant (street address, city, county, state, zip code)	
<div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div>	
ORGANIZATION NAME	GRANT NUMBER OR NAME
NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	
SIGNATURE	DATE


§ 58.16 VA Form 10-0144—Certification Regarding Lobbying.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

 Department of Veterans Affairs	
CERTIFICATION REGARDING LOBBYING	
<p>The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.</p>	
<p>This certification is made in compliance with Section 319 of Public Law 101-121; and pursuant to the Interim Final guidance published as part VII of the December 20, 1989, Federal Register (Pages 57306-52332).</p>	
<p>Certification for Contracts, Grants, Loans, and Cooperative Agreements</p>	
<p>The undersigned certified, to the best of their knowledge and belief, that:</p>	
<p>(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.</p>	
<p>(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Forms-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.</p>	
<p>(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.</p>	
<p>This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31 U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</p>	
SIGNATURE OF CERTIFYING OFFICIAL	DATE
NAME AND TITLE OF CERTIFYING OFFICIAL	PROJECT (FAI NUMBER)
NAME AND ADDRESS OF STATE AGENCY	

§ 58.17 VA Form 10-0144A—Statement of Assurance of Compliance with Equal Opportunity Laws.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

 Department of Veterans Affairs	
STATEMENT OF ASSURANCE OF COMPLIANCE WITH EQUAL OPPORTUNITY LAWS	
<p>The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.</p>	
<p style="text-align: right;">(hereinafter called the "Signatory")</p> <p>_____ (Name of Organization, Institution, or Individual)</p>	
<p>HEREBY AGREES THAT:</p> <p>It will comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972, as amended (20 U.S.C. 1681 et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), and all Federal regulations adopted to carry out such laws. This assurance is directed to the end that no person in the United States shall, on the ground of race, color, national origin (Title VI), handicap (Section 504), sex (Title IX, in education programs and activities only), or age (Age Discrimination Act) be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity of the Signatory receiving Federal financial assistance or other benefits under statutes administered by VA (Department of Veteran Affairs), the ED (Department of Education), or any other Federal agency. This assurance applies whether assistance is given directly to the recipient or indirectly through benefits paid to a student, trainee, or other beneficiary because of enrollment or participation in a program of the Signatory.</p> <p>The Signatory HEREBY GIVES ASSURANCE that it will promptly take measures to effect this agreement.</p> <p>If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Signatory or ED, this assurance shall obligate the Signatory, or in the case of transfer of such property any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. In all cases, this assurance shall obligate the Signatory for the period during which the Federal financial assistance is extended to any of its programs by VA, ED or any other Federal agency.</p> <p>THIS ASSURANCE is given in consideration of and for the purpose of obtaining Federal financial assistance, including facilities furnished or payments made under sections 104 and 244(l) of Title 38, U.S.C. Also, sections 1713, 1720, 1720A, 1741-1743, 2408, 5902(a)(2), 8131-8137, 8151-8156 (formerly 613, 620, 620A, 641-643, 1008, 3402(a)(2), 5031-5037, 5051-5056 respectively) and 38 U.S.C. chapters 30, 31, 32, 35, 36, 82, and 10 U.S.C. chapter 106. Under the terms of an agreement between VA and ED, this assurance also includes Federal financial assistance given by ED through programs administered by that agency. Federal financial assistance is understood to include benefits paid directly to the Signatory and/or benefits paid to a beneficiary contingent upon the beneficiary's enrollment in a program or using services offered by the Signatory.</p> <p>The Signatory agrees that Federal financial assistance or other benefits will be extended in reliance on the representations and agreements made in this assurance; that VA or ED will withhold financial assistance, facilities, or other benefits to assure compliance with the equal opportunity laws; and that the United States shall have the right to seek judicial enforcement of this assurance.</p> <p>THIS ASSURANCE is binding on the Signatory, its successors, transferees, and assignees for the period during which assistance is provided. The Signatory assures that all contractors, subcontractors, subgrantees, or others with whom it arranges to provide services or benefits to its students or trainees in connection with the Signatory's programs or services are not discriminating against those students or trainees in violation of the above statutes.</p>	
SIGNATURE OF AUTHORIZED OFFICIAL	DATE
NAME AND TITLE OF AUTHORIZED OFFICIAL	
MAILING ADDRESS OF AUTHORIZED OFFICIAL	

VA FORM 10-0144A
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